TROTWOOD-MADISON CITY SCHOOLS PERMISSION FOR PRESCRIPTION MEDICATION 2019 -2020

SCHOOL _____ GRADE _____ DATE REC'D _____

STUDENT _____ DATE OF BIRTH _____

ADDRESS _____

To be completed by physician or authorized prescriber

Reason for medication _____

Name of medication _____

Form of medication/treatment ___Tablet/capsule ___Liquid ___Inhaler ___Injection ___Nebulizer ___Other

Instructions for schedule and dose to be given at school _____

_____

Start _____ Date form received Other date _____

Stop _____ End of school year Other date/duration _____

_____ For episodic/emergency events only

Restrictions and/or import side effects _____ None anticipated

Please describe _____

Special storage requirements ____ None ____ Refrigerate Other _____

Student is both capable and responsible for self-administering this medication ___No ___ Yes-supervised ___ Yes-Unsupervised

Please indicate if you have provided additional information _____ On back of this form _____ As an attachment

Date _____ Physician's signature _____

Physician's Name _____

Address _____

Phone Number _____

To the school: Please report concerns about medications of disease to the above physician.

To be completed by parent/guardian

I give permission for _____ to receive the above medication at school
(Student Name)

according to the Trotwood-Madison City Schools district policy.

MEDICATION MUST BE BROUGHT TO SCHOOL IN ITS ORIGINAL CONTAINER.

I understand that the school personnel are not legally obligated to administer oral medication to any child. Therefore, I agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered.

I will notify the school immediately of any change in physician or medication or if the use of this medication is terminated for any reason

Signature of parent/guardian _____ Relationship to student _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date _____